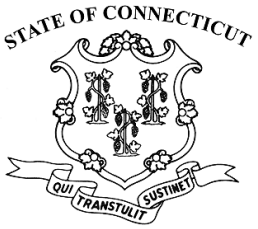

House Bill No. 5379

Public Act No. 16-21

AN ACT CONCERNING REMOVAL OF OBSOLETE PROVISIONS FROM THE CHOICES HEALTH INSURANCE ASSISTANCE PROGRAM STATUTE.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Section 17a-314 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(a) As used in this section:

(1) "CHOICES" means Connecticut's programs for health insurance assistance, outreach, information and referral, counseling and eligibility screening; and

(2) "CHOICES health insurance assistance program" means the federally recognized state health insurance assistance program funded pursuant to P.L. 101-508 and administered by the Department on Aging, in conjunction with the area agencies on aging and the Center for Medicare Advocacy, that provides free information and assistance related to health insurance issues and concerns of older persons and other Medicare beneficiaries in Connecticut. **[**; and**]**

[(3) "Medicare organization" means any corporate entity or other organization or group that contracts with the federal Centers for

Medicare and Medicaid Services to serve as a Medicare health plan organization to provide health care services to Medicare beneficiaries in this state as an alternative to the traditional Medicare fee-for-service plan.**]**

(b) The Department on Aging shall administer the CHOICES health insurance assistance program, which shall be a comprehensive Medicare advocacy program that provides assistance to Connecticut residents who are Medicare beneficiaries.

(c) The program shall provide: (1) Toll-free telephone access for consumers to obtain advice and information on Medicare benefits, including prescription drug benefits available through the Medicare Part D program, the Medicare appeals process, health insurance matters applicable to Medicare beneficiaries and long-term care options available in the state at least five days per week during normal business hours; (2) information, advice and representation, where appropriate, concerning the Medicare appeals process, by a qualified attorney or paralegal at least five days per week during normal business hours; (3) information through appropriate means and format, including written materials, to Medicare beneficiaries, their families, senior citizens and organizations regarding Medicare benefits, including prescription drug benefits available through Medicare Part D and other pharmaceutical drug company programs and long-term care options available in the state; (4) information concerning Medicare plans and services, private insurance policies and federal and state-funded programs that are available to beneficiaries to supplement Medicare coverage; (5) information permitting Medicare beneficiaries to compare and evaluate their options for delivery of Medicare and supplemental insurance services; (6) information concerning the procedure to appeal a denial of care and the procedure to request an expedited appeal of a denial of care; and (7) any other information the program or the Commissioner on Aging deems

relevant to Medicare beneficiaries.

(d) The Commissioner on Aging may include any additional functions necessary to conform to federal grant requirements.

[(e) The Insurance Commissioner, in cooperation with, or on behalf of, the Commissioner on Aging, may require each Medicare organization to: (1) Annually submit to the Insurance Commissioner any data, reports or information relevant to plan beneficiaries; and (2) at any other times at which changes occur, submit information to the Insurance Commissioner concerning current benefits, services or costs to plan beneficiaries. Such information may include information required under section 38a-478c.

(f) Each Medicare organization that fails to file the annual data, reports or information requested pursuant to subsection (e) of this section shall pay a late fee of one hundred dollars per day for each day from the due date of such data, reports or information to the date of filing. Each Medicare organization that files incomplete annual data, reports or information shall be so informed by the Insurance Commissioner, shall be given a date by which to remedy such incomplete filing and shall pay said late fee commencing from the new due date.

(g) Not later than June 1, 2001, and annually thereafter, the Insurance Commissioner, in conjunction with the Healthcare Advocate, shall submit a list, in accordance with the provisions of section 11-4a, to the Governor and to the joint standing committees of the General Assembly having cognizance of matters relating to aging, human services and insurance, of those Medicare organizations that have failed to file any data, reports or information requested pursuant to subsection (e) of this section.**]**

[(h)**]** (e) All hospitals, as defined in section 19a-490, which treat

persons covered by Medicare Part A shall: (1) Notify incoming patients covered by Medicare of the availability of the services established pursuant to subsection (c) of this section, (2) post or cause to be posted in a conspicuous place therein the toll-free number established pursuant to subsection (c) of this section, and (3) provide each Medicare patient with the toll-free number and information on how to access the CHOICES program.

[(i)**]** (f) The Commissioner on Aging may adopt regulations, in accordance with chapter 54, as necessary to implement the provisions of this section.

Approved May 17, 2016